



Contract for Controlled Substance Prescriptions

Controlled substance medications (i.e., benzodiazepines, Suboxone, and stimulants.) are very useful, but have potential for misuse; therefore, they are controlled by local, state and federal government. They are intended to improve function and/or ability to work, not simply to feel good. Because my provider is prescribing such medications for me to help manage my condition, I agree to the following conditions: **Please read each one carefully and initial where indicated.** (*PATIENT INITIAL)

1. **I am responsible for my controlled substance medications.** If the prescription of medication is lost, misplaced, or stolen, or if I take other than prescribed, I understand that it will not be replaced.
* PATIENT INITIAL _____
2. **I will not request or accept controlled substance medication from any other physician or individual while I am receiving same medication from Sherbondy's Psychiatric Services.** Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted to a hospital. * PATIENT INITIAL _____
3. **Refills of controlled substance medication:**
 - a. **Appointment will not be made if I "run out early,"** I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
 - b. **Will not be made as an "emergency,"** such as a Thursday afternoon because I suddenly realize that I will run out tomorrow and the office will be closed **I will call at least seventy-two (72) hours** in advance if I need assistance with a controlled medication prescription.
 - c. **No Controlled Medications** will be ordered when the office is closed. * PATIENT INITIAL _____
4. **I understand the importance of following my treatment plan as directed by my physician/provider and agree:**
 - a. **To keep my appointments (including follow-ups and any referrals)**
 - b. **To permit urine drug screening without prior notice.** *PATIENT INITIAL _____
5. I understand that if I **violate any of the above conditions,** my controlled substance prescription and/or treatment with Sherbondy's Psychiatric Services, may be terminated immediately. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to other healthcare providers, medical facilities, pharmacies, and other authorities. * PATIENT INITIAL _____
6. I understand that the **main treatment goal is to improve my ability to function and/or work.** In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by the following better health habits: non-use of "street drugs" I understand that using "street drugs" will impact my progress and counteract with any prescribed medications. They are not only mind altering, but also illegal. Continued use after warning can be cause for your care to be terminated immediately from Sherbondy's Psychiatric Services and may be reported to the authorities.
*PATIENT INITIAL _____

I, _____ have read this contract and fully understand its content. In
Print Name

addition, I fully understand the consequences of violating this contract.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____